Appendix 2

Sample Presumptive Eligibility for Pregnant Women Application

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10081 (Rev. 11/04)

STATE OF WISCONSIN
103.03(4), Wis. Admin. Code

WISCONSIN MEDICAID

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN APPLICATION

Providing or applying for a Social Security Number (SSN) is voluntary; however, any person who wants Wisconsin Medicaid but does not provide an SSN or apply for one will not be eligible for benefits. SSNs and personally identifiable information will be used only for the direct administration of the Medicaid Program.

SECTION I — NON-FINANCIAL ELIGIBILITY

Client Information	Preferred language (other than English) in which to receive information:	
Name — Client (Last, First, M.I.)	Birth Date (MM/DD/YY)	Telephone Number
Address (Street / P.O. Box, City, State, Zip Code)		County of Residence

1. Are you currently eligible for Wisconsin Medicaid? (If "Yes", stop here.)	❑ YES	❑ NO
2. Are you a U.S. citizen? (If you answered "No" to question 2, stop here. The provider cannot determine your presumptive eligibility.)	❑ YES	❑ NO

SECTION II — FINANCIAL ELIGIBILITY

1. How many family members, in the same household, live on this income? Include the number of medically verified fetuses.		
2. Enter the amount of money earned monthly before any deductions. Include spouse's income or, if client is a never-married minor living with her parent(s), include parent(s)' income. NOTE: Include any self-employment income minus costs (use monthly average).	$	
3. Enter allowable work-related expense deduction for each employed household member.	$	
4. Enter allowable amount of dependent care.	$	
5. Enter total allowable deductions (add lines 3 and 4).	$	
6. Enter net-earned income (subtract line 5 from line 2).	$	
7. Enter total unearned income (VA, SSA, contributions, unemployment compensation, etc.).	$	
8. Enter total net income (add lines 6 and 7).	$	
9. Compare the total net income (line 8) with the monthly standard for the appropriate family size from the income guidelines. Does the client meet the eligibility income limits?	❑ YES	❑ NO

SECTION III — VERIFICATION OF PREGNANCY

Positive pregnancy. Expected delivery date (MM/DD/YY)

SECTION IV — NOTICE

10. ❑ I certify that the above-named client has a medically verified pregnancy, and that based on the preliminary information provided above, she qualifies for Wisconsin Medicaid presumptive eligibility for pregnant women. I have informed her of the requirement to apply by mail, telephone, or in person at her county/tribal social or human services agency by the end of the month following the current month.

OR

❑ I have determined that the above-named client is not presumptively eligible for Wisconsin Medicaid for the following reason(s)

❑ She is currently eligible for Wisconsin Medicaid. ❑ She is not a U.S. citizen. ❑ She is not a resident of Wisconsin.
❑ She does not qualify under the income guidelines. ❑ Her pregnancy cannot be verified.

Name — Qualified Provider (Type or Print)	Address — Qualified Provider	
SIGNATURE — Qualified Provider	Medicaid Provider Number	Date Signed

11. ❑ I certify, under penalty of false swearing, that the information on this application and given in connection with it is a true and complete statement of facts according to my best knowledge and belief. I understand that in order to be determined eligible for Wisconsin Medicaid, I must apply by mail, telephone, or in person before the end of the month following the month in which I was determined eligible for presumptive eligibility and that my presumptive eligibility also ends on that date.

OR

❑ I understand that I do not meet the eligibility requirements for Wisconsin Medicaid presumptive eligibility. The qualified provider named above has informed me that I may still apply for Wisconsin Medicaid.

SIGNATURE — Client	Date Signed

SECTION V — TEMPORARY IDENTIFICATION CARD

Card Validity Dates (MM/DD/YY) From	Through	Medical Status Code ❑ PE ❑ P2	Social Security Number	Agency Code

This card identifies you as being eligible to receive outpatient pregnancy-related care through the Wisconsin Medicaid program. You may receive these services from any Medicaid provider. You must present this card *before* receiving care.

Client Name and Address

This card entitles this individual to receive outpatient pregnancy-related care through the Wisconsin Medicaid program from certified Medicaid providers during the time period listed. The individual listed has been determined presumptively eligible for Wisconsin Medicaid in accordance with s.49.465, Wis. Stats.

WISCONSIN MEDICAID TEMPORARY PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN IDENTIFICATION CARD

Example only